
# STATE BOARD OF PODIATRIC MEDICAL EXAMINERS

*4201 Patterson Ave • Baltimore, MD 21215-2299 • Phone: 410-764-4785 • Fax: 410-358-3083*

## APPLICATION FOR A FULL LICENSE

FORMS AND DOCUMENTS REQUIRED:

| Item | Description | For Board Use Only |
|---|---|---|
| 1. | Application with recent passport sized photograph attached to upper right hand corner, with **notarized signature**. | |
| 2. | **NON-REFUNDABLE** Application Fee of $50.00 **plus**<br>$1050.00 January Licensure<br>$850.00 July Licensure<br>Check payable to: **State Board of Podiatric Medical Examiners** | |
| 3. | **Notarized** Residency Affidavit **or** Certification of 5 years practice, whichever is applicable. | |
| 4. | Podiatry College Transcript - **Official Copy** | |
| 5. | National Board Scores - Both Parts. Only **official reports** bearing the seal of the National Board of Podiatric Medical Examiners are acceptable. *Order Reports at 1-877-302-8952* | |
| 6. | PM Lexis Examination Scores - Only **certified reports** from the Federation of Podiatric Medical Boards are acceptable. *Order Reports at http://www.fpmb.org* | |
| 7. | Two (2) reference letters from podiatrists addressed to the Board One (1) of which must be from a podiatrist licensed in the state you are currently licensed and practicing. | 1.<br>2. |
| 8. | State Licensure Affidavit (Applicable to any applicant who is licensed in or has ever held a license in another state). **Limited/Temporary Licenses included**. | |
| 9. | **Disciplinary Score Reports** by the Federation of Podiatric Medical Boards (Applicable to any applicant who is licensed in another state). *Order Disciplinary Reports at http://www.fpmb.org* | |
| 10. | **Effective January 1, 2010: Cardio Pulmonary Resuscitation (CPR) Certification** [Basic Life Support for Healthcare Professionals] | |
| 11. | Jurisprudence Exam and Ethics Lecture | |

JANUARY LICENSURE AFTER JANUARY 1
JULY LICENSURE AFTER JULY 1

**JURISPRUDENCE EXAMINATION & ETHICS LECTURE**
**Online Lecture & Jurisprudence Examination by Board**

***STATE OF MARYLAND***
***BOARD OF PODIATRIC MEDICAL EXAMINERS***
***APPLICATION FOR A FULL LICENSE***

***Please Type or Print***

Last Name | First Name | Middle

Present Address

City | State | Zip code

Phone Number | Email Address

Permanent Address

City | State | Zip code

Phone Number

Date of Birth | Place of Birth

Social Security Number

***Note: Your social security number will be used for identification purposes and will be released to the Department of Public Safety and Correctional Services to check for any criminal convictions.***

## Name of Podiatry College Attended and Graduation Date:

**Please respond to <u>whichever</u> of the following is applicable:**

A. **POST GRADUATE CLINICAL TRAINING.** *(List all residency program attended; continue on separate page if required)*
Identify each Residency Program

***I)***

_____
Name of Facility

_____
Address

_____
Dates of Post Graduate Training

***II)***

_____
Name of Facility

_____
Address

_____
Dates of Post Graduate Training

B. **PRACTICE REQUIREMENT**. List location(s) and dates of practice.

_____

_____

_____

_____

_____

**Note:** All applicants must have either completed one year of post graduate training in a residency program <u>or</u> have a least (5) years in active clinical practice preceding application to be eligible for licensure in Maryland.

List state(s) in which you are licensed or have ever been licensed to practice Podiatry. Please note that each Licensing Board for the state listed must complete a Licensure Affidavit form.

State: _____
License Number _____
Date of original issuance: _____
Expiration Date: _____

State: _____
License Number _____
Date of original issuance: _____
Expiration Date: _____

State: _____
License Number _____
Date of original issuance: _____
Expiration Date: _____

State: _____
License Number _____
Date of original issuance: _____
Expiration Date: _____

**Continue on separate page if required**

Is your application for licensure before another State Board at this time? YES☐ NO ☐

If yes, give details: _____

Have you ever been refused examination by a State Board? YES☐ NO ☐

If yes, give name of Board and details: _____

_____

Has your license to practice in any State ever been subject of an investigation and/or disciplinary action? YES☐ NO ☐

If yes, give details: _____

_____

Have you ever been convicted of a crime? YES☐ NO ☐

If yes, give details: _____

_____

Have you ever been addicted to, or treated for addiction to drugs or alcohol? YES☐ NO ☐

If yes, give details: _____

_____

Has a malpractice suit been filed against you or has a claim for damages been settled or awarded against you? YES☐ NO ☐

If yes, give details: _____

_____

***[Reference Letters Requirements for New Applicants Only and not for Reinstatements]***

Please list two (2) podiatrists who will be providing a reference on your behalf as to character, reputation and proof of practice. Request them to send their letters **directly** to the Board.

Name: _____

Address: _____

Name: _____

Address: _____

AFFIDAVIT

I, _____ being duly sworn do hereby swear that I am the person in this application for licensure before the Maryland Board of Podiatric Medical Examiners, and that the statements herein contained are true in every respect. If granted licensure, I will comply with all requirements of the laws governing the practices of podiatry in the State of Maryland, and pledge that I shall abstain from all deceptive and fraudulent methods of practice, immoral, unethical unprofessional conduct and will conduct my practice in accordance with the Code of Ethics adopted by the profession.

_____

Signature of applicant Date

Subscribed and sworn before me this _____ day of _____

_____

NOTARY PUBLIC

My commission expires _____ SEAL AND STAMP

**Forward completed application to:**

**Board of Podiatric Medical Examiners**
**4201 Patterson Avenue, Room 310**
**Baltimore, Maryland 21215-2299**

**On-Line Application**


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## STATE LICENSURE AFFIDAVIT

THIS PORTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO LICENSING BOARD(S) IN THE STATE(S) WHERE LICENSED.

Last First Middle

Date of Birth Social Security Number

State Board Podiatry College & Date of Graduation

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THIS PORTION TO BE COMPLETED BY STATE LICENSING BOARD

License Number _____ Date of Original Issue _____

Is License in Good Standing? _____ Expiration Date of License _____

License Type: ☐ Full/Unrestricted ☐ Temporary/Limited ☐ Other, please specify:_____

Licensed by: ☐ State Examination ☐ without Examination ☐ Other, please specify:_____

Is the applicant currently the subject of a pending investigation by a licensing or disciplinary authority in your state? YES☐ NO☐ **If "yes", please attach documentation**

Have formal disciplinary proceedings been initiated against applicant's license by a disciplinary authority in your state? YES☐ NO☐ **If "yes", please attach documentation**

Has the applicant ever been warned, censured or in any other manner disciplined or has applicant's license been revoked, suspended, or in any other manner limited by a licensing or disciplinary authority in your state?
YES☐ NO☐ **If "yes", please attach documentation**

Form Completed by: Title

Signature Date

State Board

**PLEASE AFFIX BOARD SEAL**
*(not valid without board seal)*


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## RESIDENCY AFFIDAVIT

THIS PORTION TO BE COMPLETED BY APPLICANT AND FORWARDED TO THE RESIDENCY PROGRAM(S) ATTENDED

_____

Last First Middle

_____ _____

Date of Birth Social Security Number

_____

Name of Facility

_____

Address

_____

Dates of Attendance

_____

**THIS PORTION TO BE COMPLETED BY THE RESIDENCY PROGRAM DIRECTOR**

This is to certify that the above named applicant:

☐ is currently attending and has now successfully completed _____ years of postgraduate clinical training in the program listed above. **OR**

☐ has successfully completed postgraduate clinical training in the program listed above.

ADDITIONAL COMMENTS:

_____

_____

_____

_____

Name & Title of Program Director

_____

Signature of Program Director Date

( _____)_____

Office Telephone

NOTARY SEAL & STAMP

***(Not valid without seal)***